NHS England: A Call to Action

NHS England is seeking views to shape the future of general practice services in England. Each LMC is encouraged to consider the consultation documents available and respond based on the consultation questions outlined in the table below. There are 10 areas in which to consider and respond.

<table>
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<tr>
<th>1. Information, Choice and Control</th>
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<td><strong>(Please note you do not need to consider each question separately but can address the below four questions as one response)</strong></td>
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<tr>
<td>- How do we go further in publishing – and getting practices to publish – an increasing range of comparative public information?</td>
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<td>- How can we best work in partnership with CQC and the new Chief Inspector role whose inspections and ratings regime is designed to improve transparency?</td>
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<td>- How do we stimulate new forms of patient involvement and insight, including introducing the Friends and Family Test in general practice?</td>
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<td>- How best do we roll out new models of patient choice?</td>
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**RESPONSE**

The value of publishing comparative public information by practices is questionable as patients do not look at them. Is there any evidence to the contrary to this statement?

Partnership workings with CQC should be direct for exchange of data.

Use incentives for patient involvement.

Patient choice is only good where there is adequate amount of services available, however it may de-stabilise local providers who would never be able to improve quality of care if there is not enough demand.

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<th>2. Clinical Leadership and Innovation</th>
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<td><strong>(Please note you do not need to consider each question separately but can address the below four questions as one response)</strong></td>
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<td>- How can we best stimulate and create space for clinically-led innovation?</td>
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<td>- How can we challenge and support local health communities, including CCGs and health and wellbeing boards, to develop more stretching ambitions for primary care?</td>
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<td>- How do we best support integration pioneers in testing new ways of commissioning and contracting for integrated primary care and community services for people with physical and mental health conditions?</td>
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<td>- How can we best mobilise existing improvement resource (e.g. NHS IQ) and facilitate access to other potential external support for primary care transformation?</td>
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**RESPONSE**

This needs enlarged and spare capacity which can only be obtained by increasing professionals in number. Expand the workforce who would then have capacity to innovate and support health communities.

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<th>3. Freeing up Time and Resources</th>
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<td><strong>(Please note you do not need to consider each question separately but can address the below six questions as one response)</strong></td>
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<td>- How might we develop QOF so that that we preserve its essential features but create...</td>
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more flexibility for practices and reduce the feel of a tick-box culture?
- How can we get best value from enhanced services and reduce process-oriented measures?
- How should general practice IT systems develop to support more efficient and integrated working?
- How can we help improve the productivity of practice systems and processes, for example through the Productive General Practice programme?
- How can we help ensure that practices are making most effective use of all practice staff, including practice nurses and practice managers?
- How do we engage practice managers more effectively?

RESPONSE

QOF’s parameters and domains need revision about every three years so that what is achieved is not lost.

Enhanced services are very good value already and some are poorly paid hence not achieved.

Practice staff are already over stretched.

There is no yearly or half yearly time table/schedule for reporting on activity. Every demand comes with a day’s notice. This is unproductive, stressful and frustrating.

4. Defining Practice Accountabilities for High Quality
(Please note you do not need to consider each question separately but can address the below four questions as one response)

- Should we seek to develop a joint concordat with key partners that re-affirms and refreshes the core features of general practice?
- How can we put general practice at the heart of more integrated out-of-hospital services and give GPs and practices greater responsibility for coordinating care for patients?
- How should we define high quality general practice and their responsibilities/accountabilities, through the GP contract?
- How do we create synergy with the new system of CQC ratings and inspections to create a clearer sense of what patients can expect from good general practice?

RESPONSE

No one can deliver medical care more cheaply and efficiently than general practice.

Social services and secondary care should be separate entities where GPs refer to them for delivering care as required. Community care should be centred around general practice. All care agencies to be individualised and be responsible with interconnections but no overlays to improve quality. GPs are overstretched and any further responsibilities would break the system or reduce the quality of care.

5. GP Contract: Incentives for Outcomes
(Please note you do not need to consider each question separately but can address the below four questions as one response)

- How far should we create stronger incentives for both inter-practice collaboration and collaboration with other primary care providers, acute, community and social care services?
- How can we better stimulate and recognise/reward quality of care for people with co-
morbidities and complex health and care problems?

- How far should we seek to reward practices for wider outcomes, such as enhancing quality of care for long term conditions and reducing avoidable emergency admissions, or reducing incidence of strokes and heart attacks, or improving patient experience of integrated care?
- What is the potential future role for PMS and APMS contracts in stimulating innovative approaches or helping address particular local challenges?

**RESPONSE**

Incentives should be in two stages: firstly for basic work/care and then secondly for higher outcomes/better care.

PMS and APMS contracts are for delivering extra care above the GMS core work and should deliver through KPIs as perceived to innovate.

**6. Safe, Controlled Investment**

*Please note you do not need to consider each question separately but can address the below five questions as one response*

- How can CCGs, local authorities and NHS England best collaborate to develop integrated commissioning plans for out-of-hospital services?
- How can we support health investment analysis that allows for optimal balance of resources between acute and community services?
- Where commissioning plans envisage additional investment in services provided by general practice, how can CCGs and NHS England best provide assurance that any perceived conflicts of interest have been properly managed?
- How do we track value from investment and adjust investment plans to reflect evidence of outcomes?
- How can NHS England and CCGs work together to make more effective use of existing community estates and, where necessary, allow investment in new or expanded premises?

**RESPONSE**

Local authority should deliver social services and not medical services. There should be clear boundary for all services to improve quality and efficiency.

Good value is tracked by quantity and quality of work. Any KPI to be valued accordingly to this principal.

CCG should be entirely separate as commissioner with no responsibilities or overlay of provider activities. Estates and premises should be purely in NHS England’s domain with no CCG involvement.

**7. Market Management**

*Please note you do not need to consider each question separately but can address the below four questions as one response*

- How do we ensure a consistent and disciplined approach to identifying and remedying poor performance, including effective partnership with the CQC?
- How do we develop a more consistent and effective approach to new market entry, e.g. how far this should be targeted at areas of greater deprivation and/or lower capacity and/or limited patient choice?
- How might we stimulate new, innovative provider models that offer both greater quality for patients and satisfying careers for those working in general practice and
primary care?
• What are the potential opportunities for ‘primary care plus’ contracts, built on co-commissioning between NHS England, CCGs and local authorities?

RESPONSE
The cause of poor performance should be identified and rectified by planned action. This may need increased capacity and/or training.

8. Workforce Development
(Please note you do not need to consider each question separately but can address the below four questions as one response)
• How can we and our national and local partners best support improvements in recruitment, retention and return to practice?
• What are the strategic priorities for improvements in education and training to reflect the evolving role of general practice, the changing profile of the general practice workforce and the challenges facing the health service in the next ten years?
• What developments would help provide more structured careers for GPs, practice nurses and other primary care practitioners?
• What factors are likely to promote and support good employment practice, e.g. practices providing training and development opportunities for practice nurses and practice managers?

RESPONSE
Incentivisation is a great motivator. Better environment, more opportunities to refresh and train with better terms of service would help recruitment and retention. Every person should have protected time off work to train/refresh as evidenced.

9. Specific Issues and Questions
(Please note you do not need to consider each question separately but can address the below five questions as one response)
• How do we ensure that people with more complex health and care needs have a named clinician with responsibility for coordinating their care? Should people with more complex needs have a named GP with responsibility for overseeing their care?
• How can we strengthen general practice accountability for the quality of out-of-hours services provided to patients and ensure that OOH services are more integrated both with daytime general practice and with wider urgent care services?
• How do we stimulate more convenient routine access to general practice services, including ease of making appointments, speed of contact for urgent problems (whether telephone or face-to-face), ability to book less urgent appointments in advance, ability to communicate electronically (e.g. online consultations) and, particularly for working-age adults, availability of evening/weekend slots?
• How do we stimulate general practice responsiveness to access preferences of their populations?
• How far should there be a shift of resources from acute to out-of-hospital care? How far should this flow into general practice and how far into wider community services?

RESPONSE
No one could work 24 hours a day 365 days a year so named GP as responsible for complex cases is unworkable. This has to be a collective job within a team. There should be a vast increase in GP numbers to reduce practice size to 1300 from 1900 as at present. This means increasing GP workforce by 50% of present numbers. The pay of GPs should be related to workload and not just numbers.
10. Do you have suggestions for the development of our analytical pack? If so please detail them.

RESPONSE

Analytical Pack Should Look At:

1. Number of patient at different age groups.
2. Ethnicity of patient.
3. Deprivation
5. Co-morbidities of patients – each morbidity adds further point.
6. Housebound patients.
7. QOF achievements in each domain separately.
8. KPIs (if any) each domain separately.
10. Immunisations achievements.